

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27653**

Registration District No. **1** Primary Registration District No. **1** Registrar's No. **257**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Kirksville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **216 East Harrison St.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **Mary Shackett**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **12345**

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **widowed**
6. (b) Name of husband or wife **Alford T. Shackett** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **August 12 1863**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 0 23 hr. min.

9. Birthplace **Macon Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business

12. Name **Zeak. Roberts**
13. Birthplace **unknown** (City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Lydia Sholly**
(b) Address **Kirksville Mo.**

17. (a) **burial** (Burial, cremation, or removal) (b) Date thereof **9-6-41**
(Month) (Day) (Year)
(c) Place: burial or cremation **Bell Fourche S. Dakota**

18. (a) Signature of funeral director **Laura Riley**
(b) Address **Kirksville Missouri**

19. (a) **Sept 6/41** (Date received local registrar) (b) **Spencer L. Freeman** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Adair**
(c) City or town **Kirksville**
(If outside city or town limits, write "RURAL")
(d) Street No. **216 East Harrison St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **5**
year **1941** hour **five** minute **P.** M.

21. I hereby certify that I attended the deceased from **Dec. 18 1940** to **Sept. 5 1941**
that I last saw her alive on **Sept 5 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis and endocarditis**
Due to **732**

Other conditions **Chronic nephritis**
(Include pregnancy within 3 months of death)

Major findings: Of operations **1316**
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury **Q**
23. Signature **Spencer L. Freeman** (M.D. or other) Address **Kirksville** Date signed **9/6/41**

RECEIVED

District Health Officer No. 10

District File Number 9-41-1670

Date Filed SEP 16 1941

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~

_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed

Laura Riley

Licensed Embalmer No. 3907

P. O. Address Kirkville Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.